



PRESCRIPTION SERVICES PATIENT SATISFACTION SURVEY

Date: _____
 Doctor: _____

Dear Patient,

Thank you for choosing our Cancer and Blood Specialty Clinic Prescription Services for your medication needs. We value your feedback and aim to continuously improve our services. Kindly take a few moments to complete this patient satisfaction survey. Your responses will remain anonymous and will assist us in enhancing your experience and the quality of care we provide.

	Very Satisfied	Satisfied	Neutral	Dissatisfied	Very Dissatisfied
OVERALL SATISFACTION					
Overall satisfaction with our Cancer and Blood Specialty Clinic Prescription Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIPTION SERVICES STAFF					
Knowledge and expertise of our prescription services staff in addressing your medication-related concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription services staff professionalism and friendliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescription services staff efficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Confidentiality and privacy maintained during your interactions with our prescription services staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONTACTING THE PHARMACY					
Availability and accessibility of our prescription services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access via phone to a person that was able to answer your questions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIPTIONS					
Accuracy of medication dispensing and prescription refills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenience of receiving prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length of time to obtain prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foundation assistance/copay service from staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive and clear instructions on how to take your medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please provide any additional comments or suggestions to help us improve our services:

Thank you for your valuable feedback! Your input will assist us in enhancing our prescription services to better serve you and other patients. If you have any immediate concerns or questions, please do not hesitate to contact us directly.

Sincerely,
 CBSC Prescription Services